MHA MASSACHUSETTS HOSPITAL ASSOCIATION

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President and Chief Executive Officer

JudyAnn Bigby, M.D.
Secretary
Executive Office of Health and Human Services
Commonwealth of Massachusetts
One Ashburton Place, 11th Floor
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Dear Secretary Bigby:

The purpose of this letter is to provide the Health Care Quality and Cost Council (HCQCC) with a summary of the concerns from hospitals regarding the cost data that will be posted on the website. As you know, MHA supports the development of a consumer friendly website for obtaining information on hospital quality and cost. As we have previously stated, the Council has an opportunity to enhance its role as a respected resource, serve the public interest and also assist providers by helping them avoid duplicative measurement and reporting schemes that add unnecessary and counter-productive administrative complexity and cost to the system. The website is one way to accomplish this mission. But in order to become a trusted and reliable source of information, the measures that are posted on the website must be accurate and true.

At a briefing hosted by MHA on May 15th and attended by more than sixty quality, finance, and managed care directors, hospitals clearly stated that they cannot verify the accuracy of the cost data in the nine business days that they are being given to accomplish this task. While the quality data has already been reviewed through other venues and is publicly available through various websites, the cost data is completely new and untested. For all of the reasons outlined below, and most importantly so that the future credibility of the website is not compromised, MHA urges the Council to reconsider including the cost data in the June 24 launch and give hospitals additional time to review and validate the cost data.

There are still many unknowns regarding the cost data including:

- The Council itself still does not know exactly what measures will be included and whether there is enough data for each of the proposed measures to report variation.

There are still questions as to whether certain procedures, such as outpatient radiology, include both the professional and technical component or just the facility fee. Although the staff analyzing the data believed that 80% of hospitals were paid with a global payment for radiology, most of those attending the briefing stated that this was not the case at all.

- To compare costs accurately, the Council would have to know exactly which hospitals include or exclude physician expenses in their negotiated rates (or the payers "allowed costs"). Several hospitals spoke up at the meeting, and gave examples of how this can be completely different even within their own network. Substantial work needs to be done in the area of physician expenses, so that hospitals are compared fairly.

- The health plan dataset includes only fully funded commercial payers (with the exception of BCBSMA which includes self funded data). As hospitals try to reconcile this data, they will be missing self funded data for all other plans (which accounts for approximately 50% of Tufts and HPHC's business). This also calls into question how well the data reflects average payments to hospitals, and makes the verification process incredibly difficult.

- The HCQCC claims database has no patient identifier for hospitals, making it impossible for them to reconcile at the claims level. This is a major design flaw making comprehensive validation of a hospital's payment data almost impossible.

- Year end settlements; cash payments in lieu of rate increases; and capitation arrangements with interim rates will not be reflected in this data, and may cause a significant distortion in the hospital's true reimbursement from an insurer.

- At the meeting, hospitals were told that the "cost" data is actually the allowed amount on a patient's Explanation of Benefit form. This is not what providers are reimbursed in most cases. The allowed amount assumes that all patients pay their deductibles, co-pays and co-insurance. It assumes that there are no bad debts or free care secondary. It may even assume that there are no denials for a multitude of administrative or clinical reasons.

- There will be no adjustments for payer or product mix which could result in inaccurate comparisons. The payer mix issue is particularly troubling, as providers must carefully balance federal and state reimbursement with commercial reimbursement or else the institution will have to close its doors. So providers with a very disadvantageous payer mix, will have commercial only "costs" that are not an accurate portrayal of their overall "costliness". The web site should contain at least a footnote cautioning that a hospital with a disproportionate federal or state payer mix, may need to offset these losses with higher commercial payments.

- Some commercial payers have substantial administrative requirements that result in driving up the cost of health care. Hospitals in turn must negotiate higher rates from those commercial payers. There is no data on this website that speaks to the administrative overhead expenses of the various payers, which is an important component to the rising cost of health care. It was stated at the meeting, that currently 30% of every healthcare dollar is due to administrative waste. The health plans cannot be exempt from review.

- If data is deemed to be inaccurate and subsequently not posted for large or multiple hospitals, the state median will be affected, thereby changing the comparative data as well. The Council must have a process for dealing with this possibility.

MHA understands that the Council expects hospitals to review the data between May 23rd and June 6th and to determine whether the sample they are provided is representative of their private sector payments for the same period of time. Yet, given the issues raised, it will be difficult to accurately respond to this question. Each of these important considerations must be satisfactorily addressed before hospitals can be comfortable that the data being displayed is representative of their costs. Given the many questions that the data is likely to generate, it will take more than nine business days for both the Council and hospital staff to work through this process. In summary, MHA, on behalf of its member hospitals, requests that additional time be provided to hospitals to ensure that the final product on the website accurately reflects cost data for each hospital and fair comparisons among hospitals. If we don't take the time to do it right the first time, future credibility of the website will be compromised. You won't get a second chance to make a good first impression.

Sincerely,

Lynn Nicholas

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CC: Katharine London, Executive Director, HCQCC
Charles D. Baker, President & CEO, HPHC